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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Ghana

The Executive Director recommends that the Executive Board approve the country programme of Ghana for the period 1991-1995 in the amount of $11,625,000 from general resources, subject to the availability of funds, and $8,500,000 in supplementary funds, subject to the availability of specific-purpose contributions.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1990, will be contained in the "Summary of 1991 recommendations for general resources and supplementary funding programmes" (E/ICEF/1991/P/L.2).

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THE SITUATION OF CHILDREN AND WOMEN

1. The Ghanaian economy has endured a decade of crisis owing to external factors including sharp reversals in the terms of trade, high levels of debt servicing and declining net resource transfers. Despite those constraints, Ghana has made impressive progress since the adoption of the Economic Recovery Programme in 1983 as indicated by an average annual gross domestic product growth rate of 2.6 per cent during the period 1985-1988. Structural adjustment measures have, however, had a negative impact on some sectors of society. In response, the Government launched the Programme of Action to Mitigate the Social Costs of Adjustment and Development as a means of providing temporary relief to vulnerable groups that have suffered from the past decade of economic decline, as well as from the adverse, short-term effects of adjustment.

2. The Government has committed itself to a policy of decentralizing responsibility for development and the provision of social services and, in this regard, district assemblies with social sector sub-committees have been established in each district in the country. In addition, the civil service is being restructured to more effectively meet local needs, and a new National Development Planning Commission is being established to formulate, implement and monitor national development strategies and plans.

3. The Government has given increased priority to social sector programmes as demonstrated by: (a) increased per capita expenditures on health and education; (b) the implementation of major educational reforms; (c) the establishment of a National Social Mobilization Committee for Child Survival and Development; and (d) being the first country to ratify the Convention on the Rights of the Child.

4. The population of Ghana is currently estimated at some 14.6 million people and has an annual population growth rate of 2.6 per cent, with rates reaching as high as 4.5 per cent in some rural areas. Approximately 30 per cent of the population live in urban centres, while 32.4 per cent live in rural communities of under 500 inhabitants. The Government estimates that there are between 44,000 and 48,000 communities in the country scattered among 110 districts in the 10 administrative regions.

5. Poverty remains a significant and, perhaps, increasing problem, particularly in rural areas among subsistence farmers outside the market economy. Farming is the single most important occupation for rural women, who constitute 50 per cent of all workers in agriculture and animal husbandry. Data from the 1989 Ghana Living Standards Survey show that 25, 34 and 26 per cent of households in Accra, other urban areas and rural areas, respectively, are headed by women.

6. Approximately 55 per cent of the total population have access to potable water, with only 15 per cent of people living in communities of fewer than 500 inhabitants having access to this basic service. Access to adequate sanitation is limited, with only 50 per cent of the urban population and

15 per cent of the rural population having adequate sanitation, yielding a national coverage of 27 per cent.

7. The infant mortality rate was estimated at 77 per 1,000 live births for the period 1983-1987. The under-five mortality rate (U5MR) is estimated at 143 per 1,000 live births, but the rate is substantially higher in some areas. More than one third of deaths among children under five years old are caused by vaccine-preventable and infectious diseases, including malaria, measles, diarrhoeal diseases and acute respiratory infections (ARI). Approximately 1 out of every 10 children dies from causes related to malnutrition, and an almost equal number from causes related to low birth weight. Those factors account for almost 60 per cent of all deaths among children under five years old. Those same diseases are also the main causes of morbidity in children under five years old. Malaria is the cause of almost 45 per cent of all out-patient visits, followed by ARI (10 per cent) and severe diarrhoea (7 per cent).

8. The currently accepted figure for the maternal mortality rate remains unacceptably high, ranging from 500 to 1,000 per 100,000 live births. It is estimated that 4 out of every 10 maternal deaths are due to preventable causes.

9. Malnutrition remains a serious problem, with 58 per cent of children under five years old falling below 80 per cent of the correct weight for their age and 8 per cent suffering from marasmus or kwashiorkor. Micronutrient deficiencies pose a major problem, and vitamin A and iodine deficiencies are common in the Northern, Upper East and Upper West Regions. Malnutrition among women, especially pregnant and lactating mothers, is also a significant problem.

10. Approximately 9 to 10 per cent of the eligible age-group of three- to six-year-olds were enrolled in public or private pre-schools in 1987-1988. Most of the available facilities are in urban areas, are in poor physical condition and are staffed mostly by unqualified teachers. Approximately one third of children in the relevant age-group (6 to 11 years of age) do not attend primary school. Of those who do attend, 27 per cent of boys and 35 per cent of girls drop out before finishing the basic primary cycle (up to sixth grade). Children leave school primarily for economic reasons, such as the inability to pay for fees and supplies. A national study in 1989 revealed that only 11 per cent of children 9 to 14 years of age are literate, a figure that does not reflect significant gender disparity. The literacy rate of the total population nine years old and over is estimated at 32 per cent, with significant differences observed for men and women (42 and 23 per cent, respectively).

PROGRAMME COOPERATION, 1986-1990

11. A major activity during the past programme cycle was to assess the impact of economic recession and adjustment policies on vulnerable groups, especially women and children, and to bring this to the attention of government policy makers and the international donor community. This advocacy effort led to the

publication of a report by UNICEF in 1986 that played an important role in mobilizing support for a concrete response to the problems and needs, leading to the formulation of the Programme of Action to Mitigate the Social Costs of Adjustment and Development. The $85 million Programme was launched in 1988 and was targeted at rural households (particularly in the Northern, Upper East and Upper West regions), low-income, unemployed and underemployed urban households, and "redeployed" employees from the civil service and public and private enterprises. The UNICEF contribution to the Programme has focused on an essential drugs project and a project for enhancing the opportunities of women in development (in collaboration with the United Nations Development Programme (UNDP), the United Nations Development Fund for Women (UNIFEM) and the United States Agency for International Development (USAID)). A donor review of the Programme of Action to Mitigate the Social Costs of Adjustment and Development in mid-1990 noted the slow implementation of the programme owing largely to over-ambitious targets and deadlines. The mission recommended a number of measures to accelerate the programme, including reducing the number of programme areas and the number of donors for each project.

Primary health care

12. In view of limited UNICEF resources and constraints on government resources, an area-specific approach was adopted, focusing specifically on the Government's primary health care (PHC) structure, which operates from the district headquarters through an intermediary supervisory health post/centre to the community. Initially, a limited number of districts were selected to begin PHC programmes. However, at the beginning of 1987, the focus of implementation shifted to all 65 districts in the country in response to the Government promotion of PHC nationally.

Essential drugs

13. In addition to the training of health staff at all levels and the supply of drugs and dietary supplements kits for PHC facilities, a national essential drugs list was established. This has facilitated the introduction of the Government decentralized and self-financing essential drugs system ("cash and carry") of drug supply and the launching of the Bamako Initiative in 1989 in five districts, one in each of five regions.

Expanded programme on immunization

14. Following its revitalization in 1985 with the measles campaign, the expanded programme on immunization (EPI) emerged as the major entry point for enhancing PHC in Ghana. However, despite political commitment at the highest level for achieving universal child immunization (UCI) by 1990 and significant progress in developing and strengthening the cold-chain system and flow of vaccines to the village level, it was not until 1989 that this progress was reflected in improved coverage rates based on sustainable delivery systems. At the end of 1989, national vaccination coverage of children under one year old had reached 51 per cent for the third dose of combined diphtheria/pertussis/tetanus vaccine, 65 per cent for measles vaccine,

51 per cent for the third dose of polio vaccine and 99 per cent for anti-tuberculosis vaccine. Until 1989, estimates of vaccination coverage were based on a target population of children under one year old of 3.0 per cent of the total population. In 1990, the Government revised its estimates to 3.8 per cent, although early coverage estimates have not been revised to reflect this change. Although vaccination coverage has increased substantially in recent years, major efforts are still required to maintain high coverage rates and to reduce drop-out rates for multiple dose antigens. The infrastructure for maintaining an effective programme remains weak in many areas of the country owing to limited manpower and transport and the lack of in-service training, which inhibit effective static and outreach activities.

Control of diarrhoeal diseases

15. The introduction of locally produced oral rehydration salts (ORS), beginning in April 1988, created the basis for both private and public sector distribution and promotion of ORS as an effective means of diarrhoeal disease case management. Non-governmental organizations and pharmacies became actively involved, both in the distribution of ORS and in the promotion of home-made solutions. Prototype oral rehydration therapy (ORT) education materials were developed and used extensively, and other promotional methods such as drama, posters and messages in local languages on ORS sachets are also being used effectively. Since mid-1987, health and non-health personnel have been trained to use ORT, and UNICEF has supported Jaycees International in providing information on ORT to grass-roots organizations in three regions.

Training of village health workers and traditional birth attendants

16. Until 1987, the training of village health workers (VHWs) and traditional birth attendants (TBAs), and the provision of basic supplies to them, was supervised by the Ministry of Health. However, the standardization of TBA training in 1988 led to the establishment of a national standard and the initiation of the safe motherhood programme in seven pilot districts in late 1989. The programme aimed at increasing access to, and upgrading the quality of, maternal and child health (MCH) services throughout the country through improved TBA training. Trainers at the health-centre level were trained and were expected, in turn, to strengthen the training and supervision of 14,000 TBAs by 1993.

Nutrition

17. Although approval of the new national food and nutrition policy has not proceeded as rapidly as expected, efforts in the area of weaning foods, food preservation and storage and the establishment of nutrition surveillance centres have borne encouraging results. All 45 weaning foods production sites originally planned have been established in 15 districts. Subsequently, a nutrition surveillance system was also installed in one third of the weaning food sites in each district through which volunteers were trained to weigh children and maintain growth charts. Supervising technicians were also trained in compiling and relaying records to regional and national headquarters. The programme emphasized benefits to women in terms of

income-generation opportunities and the reduction of drudgery, improved child feeding and the freedom for mothers to attend to other activities. Training was provided to technical officers of the Ministries of Health and Agriculture, private district-level technicians and community mill operators. Volunteers in 21 communities were trained in growth monitoring and 110,000 growth charts were printed locally. As of 1989, an estimated 60 per cent of children in the targeted villages were registered users of growth charts. Other activities included support for the fish smoking technology in coastal, and later in inland, regions and the promotion of dry season gardening in the Northern region.

Water supply and sanitation

18. UNICEF assistance to water supply and sanitation activities centred on cooperation with the Ghana Water and Sewerage Corporation to expand water and sanitation coverage. Significant resources were directed to improving water supply and sanitation in four regions (Brong Ahafo, Eastern, Volta and Western). Activities in those regions have included the drilling of 130 boreholes and the rehabilitation of 250 others to serve health institutions, day-care centres and primary schools. Other activities designed to address needs throughout the country included improving water supply and sanitation in small communities, using appropriate technology and safe, affordable systems such as hand-dug wells fitted with pumps and protected springs, and rehabilitating rainwater harvesting systems. In the initial years, the programme focused on the training of technicians and the supply of equipment, logistics and building materials for the drilling and rehabilitating of boreholes and the harvesting of rainwater for health institutions. In subsequent years, support for the community-based supply of safe water and the construction of Kumasi ventilated improved pit latrines using local materials was emphasized.

Education

19. Only limited support was provided in the area of education, primarily to promote the establishment of a national policy on early childhood development. Basic equipment for a number of pre-school facilities was also provided, together with training for trainers of pre-school staff and support for the establishment of integrated community centres for employable skills.

Social mobilization

20. In 1988 UNICEF commissioned a study of knowledge, attitudes and practices (KAP) regarding vaccinations, the findings of which were critical in formulating specific strategies to accelerate EPI activities and to support child survival and development (CSD). The resulting surge in social mobilization efforts included the formation, in May 1989, of NSMCCSD with representatives drawn from relevant governmental, non-governmental and international organizations, and from the mass media. The main function of the National Social Mobilization Committee for Child Survival and Development was to mobilize and coordinate financial and human resources in support of CSD. The impact of those efforts has been evident in increased demand and

support for EPI, and the mobilization structure has significant potential with respect to other child-related development issues such as literacy, dracunculiasis (Guinea worm) eradication and the dissemination of information pertaining to Facts For Life to communities.

Lessons learned

21. The experiences of the last several years have highlighted a number of lessons relevant to planning future UNICEF assistance which, during the past programme cycle, became overly dispersed geographically and lacked the clarity and cohesion originally envisaged. UNICEF inputs were discussed directly with each regional administration without coordination at the national level and, as a result, central ministries had little idea of what activities were actually taking place in each region and district. The mid-term review, held in July 1988, noted those concerns and recommended closer coordination and monitoring of UNICEF assistance within the context of the Government decentralization policy. The mid-term review also recommended the establishment of a Social Sector Coordinating Committee in each region to oversee all external inputs to each region, including those of UNICEF, and pointed out the need to improve planning. However, in practice, this proved difficult to implement, and the lack of a comprehensive plan agreed to at all levels contributed to a continued relative lack of coherence. In addition, appropriate and sustainable interventions depend on the active involvement of communities in decision-making, resource mobilization and monitoring in order to ensure sustainability.

RECOMMENDED PROGRAMME COOPERATION, 1991-1995

Recommended general resources: $11,625,000
Supplementary funding: $ 8,500,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health and nutrition	4 078	5 005	9 083
Water supply and sanitation	1 479	2 032	3 511
Basic education	1 925	1 463	3 388
Social mobilization	1 305	-	1 305
Planning, monitoring and evaluation	854	-	854
Programme support	1 984	-	1 984
Total	11 625	8 500	20 125

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also approved supplementary funding projects shown in table 3.

Programme preparation process

22. Soon after the mid-term review, the Government and UNICEF started preparing a situation analysis of children and women, the first draft of which was reviewed at a workshop in January 1990. Subsequently, a draft strategy paper was prepared for discussion at a programme strategy meeting in March 1990, which recommended the convening of a Programme Formulation Task Force. The draft master plan of operations was discussed at a joint Government/UNICEF programme preview meeting in June 1990.

23. The new programme of cooperation will seek to enhance significantly the well-being of children and women in Ghana, with the following general objectives: (a) reduce U5MR by approximately 15 per cent by 1995; (b) reduce maternal mortality by 25 per cent; (c) improve access to basic education for children and literacy for women; (d) enhance the capacity to plan and implement social development initiatives, especially at district and community levels, with an emphasis on women's involvement; and (e) increase the knowledge of essential health information (Facts For Life) on the part of parents, especially mothers.

24. Operationally, the programme of cooperation will consist of five sectoral programmes which will seek to demonstrate the potential of full integration of services in 10 specific districts, one in each of the 10 regions in the country, selected by regional administrations on the basis of potential and needs. Together, the 10 districts have a total population of 1.35 million people.

Health and nutrition

25. Specific objectives of the health and nutrition programme will include: (a) a 30 per cent increase in the availability, accessibility and utilization of basic services in underserved areas; (b) the reduction of reported cases of EPI vaccine-preventable diseases, with particular efforts to eliminate neonatal tetanus by 1995, and towards the eradication of poliomyelitis by the year 2000; (c) the reduction of child mortality and morbidity associated with diarrhoea by 20 and 10 per cent, respectively; and (d) the reduction of malnutrition levels by one third. The programme will include the following five projects:

(a) The district PHC development (Bamako Initiative) project will support the strengthening of a comprehensive PHC programme so far hindered by problems that include the lack of integration between the organization and delivery of services; the over-centralization of decision-making; and limited community participation. In addition, drug shortages and the inadequate availability of MCH equipment also constrain programme implementation. In conjunction with the provision of essential drugs, communities will be trained to manage and distribute drug supplies on a cost-plus margin basis. Profits earned will be used by the unit committees (village government) to finance other PHC-related interventions (such as water supply, nutrition and child-care centres) determined by each community in consultation with district officials;

(b) Support to the safe motherhood project will finance activities in three regions as part of national safe motherhood efforts which seek to reduce mortality and morbidity owing to pregnancy-related conditions through improved coverage and quality of pre-, peri- and post-natal care and services related to family spacing. The Ministry of Health and UNICEF will address the problems of maternal health within the context of nationally formulated policy guidelines that include the identification of required inputs (such as MCH equipment and supplies, antenatal drugs, financial and logistical support); training and refresher courses for health personnel at all levels, especially for the supervision of TBAs; expanding facilities and upgrading existing referral points and systems; creating awareness and upgrading the knowledge among non-health personnel, especially policy makers, assemblymen and women, students, church groups, women's groups and community leaders about child spacing, pregnancy, labour, the prevention of acquired immunodeficiency syndrome (AIDS) and available facilities and services; and strengthened communication links among the levels of the PHC system to permit the timely treatment of cases by qualified personnel at referral points. UNICEF will assist the supervision of the trained TBAs and VHWs by training the supervisory midwives;

(c) The EPI and control of diarrhoeal diseases project will seek to maintain 80 per cent vaccination coverage by vaccinating children under one year old, pregnant women and women of child-bearing age in every community in the country, and will attempt to reach 85 per cent coverage of children under one year old nation-wide through a 50 per cent increase in static and outreach immunization services. The principal approaches will include strengthening national, regional and local infrastructures for vaccination delivery; strengthening the integration of EPI and PHC; improving epidemiological surveillance; and increasing demand for vaccinations through social mobilization. Micro-planning techniques will be included in in-service training workshops. Efforts will be made to achieve and sustain 100 per cent vaccination coverage in the 10 selected districts. In addition, the project will combine training on the use of ORS with EPI training in order to help improve diarrhoea case management and ensure access to ORS to 80 per cent of affected children under five years old between 1991-1995. The project will ensure 80 per cent access to ORS by 1993;

(d) The food and nutrition policy development project will seek to reduce malnutrition by promoting the adoption and implementation of the national food and nutrition policy, its integration into national development plans and the establishment of administrative mechanisms for coordination;

(e) The control of iodine deficiency disorders (IDD) project will provide information on the extent of IDD and will help to establish two monitoring laboratories to determine levels of urinary iodine. In addition, iodine supplements in the form of iodized oil will be provided to treat at-risk populations in endemic areas.

Water supply and sanitation

26. The water supply and sanitation programme will seek to improve the health and productivity of communities through the provision of improved water supply and sanitation, with an emphasis on small villages that have not yet benefited significantly from the development of water resources in Ghana. The primary geographic focus of the programme will be on dracunculiasis endemic areas as identified in the 1989 National Guinea Worm Search Survey. In order to provide those services, the programme will focus on efforts to increase access to clean drinking water and to improve environmental sanitation and personal hygiene in small rural communities. The programme will rely heavily on increased community participation, training of district staff and communities, use of appropriate, low-cost and replicable technologies, the expanded use of hygiene education and improved coordination among government agencies and donors.

Rural water supply project

27. This project will focus primarily on small communities of less than 500 people, with a special focus on dracunculiasis endemic areas. The project will benefit a total of approximately 620,000 people by assisting with the construction or rehabilitation of hand-dug wells equipped with hand-pumps, the drilling and rehabilitation of boreholes, the development of alternative, small-scale water technologies such as spring boxes and infiltration galleries, and the provision of chemicals and filters to combat dracunculiasis.

Environmental and domestic sanitation project

28. The project will complement the water supply project and aims to increase rural sanitation, with a primary focus on communities of less than 500 inhabitants. The project will focus on the promotion and construction of sanitary facilities and, in collaboration with the mobilization programme and with support from the Department of Community Development, will seek to improve knowledge and practices related to personal hygiene and sanitation. The project will construct 1,200 communal and household demonstration units to serve approximately 60,000 rural people directly.

Basic education

29. In response to the World Conference on Education for All, a new programme on basic learning needs will be supported beginning in 1991 to address the lack of instruction manuals and supplementary reading materials on the newly introduced life skills syllabus (on personal hygiene and health) in primary and junior secondary schools. The programme will address the shortage of material resources to support the national functional literacy programme; the lack of a national policy on pre-school education; and the inadequacy of pre-school care, particularly in rural communities. The programme will also address issues relating to the pre-school child and will seek to equip school-age children and non-literate adults, particularly women, with the basic knowledge and skills they require to enhance their welfare and that of young children.

Life skills in primary schools project

30. This project will support the incorporation of the components of Facts for Life in the curricula of 10,120 primary and 5,000 junior secondary schools reaching some 2.3 million children aged 6 to 15 years old throughout the country. In addition to supporting the design and production of resource books for some 100,000 teachers and supplementary reading materials for pupils, the project will link the school system with communities in the promotion of convergent basic services.

Non-formal education project

31. The project will support the provision of functional literacy skills to adults, particularly women, and to children not attending school. It will be coordinated with the social mobilization programme to equip women, especially the non-literate, with the basic knowledge and skills they require to enhance their welfare and that of their children.

Early childhood development project

32. The project will seek to reduce the workload of women and to increase the schooling of young girls while promoting the physical, cognitive and psycho-motor development of children under six years of age by promoting the establishment of community-based pre-schools. The project will also address such national issues as policy development and institutional strengthening at national level, in addition to promoting efforts to improve pre-school facilities and non-formal child care.

Social mobilization

33. The social mobilization programme will seek to ensure the effective utilization of basic services by improving the KAP of the population, especially women, with respect to basic preventive health measures and PHC interventions. Building on past experience, communities will be mobilized through the promotion of messages related to Facts For Life, AIDS, women and other critical messages through both formal and traditional (non-formal) communication channels. The programme will support all other programmes by creating and sustaining a process of social change with respect to KAP, and, as a result, demand for services, and by generating commitment at all levels to maintain and expand basic services.

Advocacy and mobilization of allies project

34. The project will provide institutional support, orientation and training to Social Mobilization Committees for Child Survival and Development at national, regional, district and community levels to address the lack of knowledge of health issues, child rights and other critical issues among leaders and decision makers. Special emphasis will be given to ensuring that committee members are fully conversant with Facts For Life messages and are sensitized to the roles and needs of women. The committees will serve as key

actors in all other projects within the programme. The project will carry out advocacy on children's and women's issues with approximately 50,000 people comprising national, regional, district and local leaders.

Mass media development project

35. The project will aim to improve production facilities, equipment and materials used by both the electronic and print media and to increase the number of journalists conversant with reporting on CSD, child rights and women's issues. The project will strengthen media capacity to research and report on the special needs and concerns of women and children, especially in the area of social development issues relating to health education, etc. Awards for excellence in reporting on children's issues will be instituted and presented in conjunction with the annual release of the UNICEF State of the World's Children report.

Planning, monitoring and evaluation

36. The planning, monitoring and evaluation programme will support the overall programme of cooperation by strengthening the collection and analysis of data, especially that related to the situation of children and women. By providing essential and timely information, the programme will support improved multisectoral coordination within the context of the decentralized administrative structure and will also provide the data upon which all national advocacy efforts will be based.

Social statistics

37. This project will provide information to planners at the national and regional levels and in the 10 selected districts. These personnel will be provided with the data collected and further oriented so as to make maximum use of this data in prioritizing development needs and planning activities within their jurisdiction. In addition, a total of 1,168 communities in the 10 selected districts will benefit from carrying out community surveys based on participatory research methodology by 1995. Indirectly, all children and women will benefit from improvements in the planning, design and implementation of development efforts made possible by the data to be provided through this project.

Programme monitoring and evaluation

38. This project will facilitate the implementation and monitoring of UNICEF-assisted interventions by strengthening, developing and utilizing systems to collect and process data related to programme implementation. Particular emphasis will be given to the development of easy-to-use software packages for planning and monitoring inputs. Once developed, the use of the systems at all levels will facilitate the aggregation of data to provide a national overview, as well as regional and district breakdowns of relevant data. Appropriate technical and material support will be provided at each level. One programme will be evaluated each year, producing a total of six

evaluations during the period 1991-1995. The evaluations will be geared primarily to serve programme planners and implementers and, when required, donors who have provided resources for supplementary-funded programmes.

Coordination and management of the country programme

39. UNICEF assistance to the Government will be coordinated by the Ministry of Finance and Economic Planning, together with the relevant sectoral ministries and other government institutions. The Ministry will also ensure adequate coordination with other donor organizations in order to reduce duplication of efforts and ensure maximum impact on the beneficiary populations. In all programmes and projects targeted at the regional and district levels, the Ministries of Local Government and of Mobilization and Social Welfare will be essential partners, under the general direction of the Ministry of Finance and Economic Planning.

40. Effective collaboration with other national, international and bilateral agencies will be a major goal of advocacy activities in order to help ensure that successful models of intervention are expanded and, with or without UNICEF assistance, universally applied.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Ghana (1989 and earlier years)

UNICEF country classification

Under-five mortality rate	143	(1989)	Very high U5MR
Infant mortality rate	87	(1989)	High IMR
GNP per capita	$ 400	(1988)	Low GNP
Total population	15 million	(1989)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1989
Births	(thousands)	403	482	558	628
Infant deaths (under 1)	(thousands)	45	49	52	55
Under-five deaths	(thousands)	74	80	86	90
Under-five mortality rate (per 1,000 live births)		184	166	155	143
Infant mortality rate (under 1) (per 1,000 live births)		112	101	94	87

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1987-1988)	Moderate & severe	..	27
	Severe	..	6
Babies with low birth weight (%, 1979/1988)		..	17*
Children completing primary level (% of first grade, 1977/1988)		75*	..

NUTRITION INDICATORS	About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1988)	91/ 90/ 72	90*/ 92*/ 87*
Prevalence of wasting (%, 1980/1987-1988)	28	15
Prevalence of stunting (%, 1980/1988)	31	39
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)	76	76
Food production per capita index (Index 1979-1981=100, 1980/1989)	101	111
Household expenditure (% of total income, 1988) All food/cereals		66*/..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1987-1988)			21
Access to health services	Total	..	60
(% of population, 1980/1987)	Urban/rural	../..	92/ 45
Access to safe water	Total	45	56
(% of population, 1980/1987)	Urban/rural	72/ 33	93/ 39
Access to adequate sanitation	Total	27	30
(% of population, 1980/1987)	Urban/rural	47/ 17	61/ 16
Births attended by trained personnel (%, 1980/1989)		..	55*
Maternal mortality rate (per 100,000 live births, 1979/1984)		..	1000

Immunization		1981	1985	1988	1989
One-year-olds (%) immunized against:	Tuberculosis	67	41	56	99
	DPT	22	23	33	51
	Polio	25	18	33	51
	Measles	23	..	47	65
Pregnant women (%) immunized against	Tetanus	11	2	19	19

TABLE 1 (continued)

Ghana

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	72/ ..	73/ ..
(%, 1980/1988)	Male	80/ ..	81/ ..
	Female	64/ ..	66/ ..
Secondary enrolment ratio (gross/net)	Total	37/ ..	39/ ..
(%, 1980/1988)	Male	46/ ..	47/ ..
	Female	28/ ..	30/ ..
Adult literacy rate, 15 years & older	Total	31	53
(%, 1970/1985)	Male/female	43/ 18	64/ 42
Radio/television sets (per 1,000 population, 1980/1988)		195/11	294/13

DEMOGRAPHIC INDICATORS		1970	1980	1985	1989	2000**
Total population	(millions)	8.6	10.7	12.8	14.6	20.6
Population aged 0-15 years	(millions)	..	5.1	6.1	6.9	9.6
Population aged 0-4 years	(millions)	..	1.9	2.4	2.7	3.5
Urban population (% of total)		29	31	32	33	38
Life expectancy at birth	Total	49	52	53	55	59
(years)	Male	47	50	51	53	57
	Female	51	53	55	56	61
Total fertility rate		6.7	6.5	6.4	6.4	5.7
Crude birth rate (per 1,000 population)		46	45	45	44	40
Crude death rate (per 1,000 population)		17	15	14	13	10

		About 1980	Most recent
Contraceptive prevalence rate (%, 1979/1988)		10	13
Population annual growth rate	Total	2.2	3.4
(%, 1965-1980/1980-1989)	Urban	3.4	4.1

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1988)		-0.8	-1.4
Inflation rate (%, 1965-1980/1980-1988)		23	46
Population in absolute poverty (%, 1977/1987)	Urban/rural	../..	59*/ 37*
Household income share (%, 1977/1988)	Top 20%/bottom 40%	../..	.. / ..
Government expenditure	Health/education	7/ 22	9 / 26
(% of total expenditure, 1980/1988)	Defence	4	3
Household expenditure (% of total income, 1980-1985)	Health/education		3 / 5
Official development assistance:	$US millions	193	474
(1980/1988)	As % of GNP	4	8
Debt service (% of goods & services exports, 1980/1988)		8	20

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1986-1990

(In thousands of United States dollars)

COUNTRY: GHANA
LATEST BOARD APPROVAL: 1986
GENERAL RESOURCES: $8,574,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	3062	3114	123	155	26	2	284	107	3495	3378	6873
Water supply and sanitation	1072	480	39	7	56		148	32	1315	519	1834
Nutrition	261	198	12	17			93	22	366	237	603
Education	24	210	8	2				98	32	310	342
Community organization and development	136	11	6				123		265	11	276
Young child development	19		21						40		40
Women-centred programme	92	9	24	16			50	15	166	40	206
Advocacy	20	6		24	13		55	7	88	37	125
Emergency	1	107				5			1	112	113
Planning and project support	754	15	28		1391	20	635	23	2808	58	2866
Freight	909	171							909	171	1080
GRAND TOTAL	6350	4321	261	221	1486	27	1388	304	9485	4873	14358

GR = General resources.
FSF = Funded supplementary funding.

/...

TABLE 3. PLANNED EXPENDITURE, 1991-1995

(In thousands of United States dollars)

Country: GHANA Period covered: 1991-1995	Funding status	1991	1992	1993	1994	1995	Total
Health	GR	643	748	876	850	961	4078
	FSF	510					510
	NSF	817	854	1269	1244	821	5005
Water supply and sanitation	GR	298	326	319	277	259	1479
	NSF	219	432	467	521	393	2032
Education	GR	387	428	355	366	389	1925
	NSF		223	376	458	406	1463
Social mobilization and advocacy	GR	260	325	270	225	225	1305
Planning and social statistics	GR	257	91	157	242	107	854
Programme support	GR	480	407	348	365	384	1984
TOTAL	GR	2325	2325	2325	2325	2325	11625
	FSF	510					510
	NSF	1036	1509	2112	2223	1620	8500
GRAND TOTAL		3871	3834	4437	4548	3945	20635

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: GHANA	Number of posts	Amount (thousands of United States dollars)
FINANCED FROM 1992-1993 PROPOSED BUDGET:		
International Professional established posts	3	680
Local national Professional and General Service established posts	11	203
Operating costs		629
Total	14	1512
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	6	1241
Supplementary funds		
Local national Professional and General Service project posts		
General resources	25	470
Supplementary funds		
Total	31	1711

a/ For information source, see 1992 post authorization table, dated January 1991.

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1991 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Guinea

The Executive Director recommends that the Executive Board approve the country programme of Guinea for the period 1991-1995 in the amount of $9,250,000 from general resources, subject to the availability of funds, and $15,250,000 in supplementary funds, subject to the availability of specific-purpose contributions.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme co-operation at the end of 1990, will be contained in the "Summary of 1991 recommendations for general resources and supplementary funding programmes" (E/ICEF/1991/P/L.2).

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THE SITUATION OF CHILDREN AND WOMEN

1. Guinea emerged from 26 years of totalitarian rule in 1984. Since then, the Government has taken various measures to create a climate conducive to socio-economic development. But, the legacy of a quarter century of State control of every aspect of life, with the resultant inefficiency, decayed infrastructure and collapse of health and other social services, is proving difficult to surmount.

2. Since 1985, economic reconstruction has been a top government priority. Supported by the International Monetary Fund (IMF), the International Bank for Reconstruction and Development (IBRD), the African Development Bank (AfDB) and bilateral donors within the context of a structural adjustment programme, the first step was to create a financial, economic and administrative framework backed up by investment in infrastructure to achieve economic growth. Between 1986 and 1989, the economy is estimated to have grown at an average annual rate of 4.2 per cent, compared with a population growth rate of 2.8 per cent per annum. The total value of exports rose from $484 million in 1986 to $631 million in 1989. Guinea produces 14 per cent of the world's bauxite, making it the second largest exporter of the mineral, and the industry accounts for 87 per cent of the country's export earnings and employs 6 per cent of its active population. The State is dependent upon this single industry for 50 per cent of its budget, making it highly vulnerable to price fluctuations. Gold and diamonds account for 8 per cent of the total value of export earnings. As a result of various debt rescheduling exercises and debt forgiveness, Guinea was able to reduce its debt service burden from 26 per cent of export earnings in 1987 to 20 per cent in 1989. Total debt as a proportion of the gross national product decreased slightly, from 82 to 79 per cent, during the same period.

3. Although the Government has accepted policies advocated by UNICEF to mitigate the adverse effects of the structural adjustment programme upon the most vulnerable groups, this has not been reflected in the allocation of resources. The main tangible progress has been in government adoption of the Bamako Initiative, which has extended basic health services to one half of the population, and in the additional recruitment of health and education staff in the face of retrenchment in other sectors. However, at 2.5 and 13.4 per cent, respectively, in 1989, the health and education budgets are lower than the 1985 figures of 3.4 and 14 per cent, respectively. The impact of the average 40 per cent increase in prices between 1987 and 1989 on the 75 per cent of the urban population living below the poverty line remains unmitigated. The extent of this poverty is highly visible in Conakry, with its dilapidated infrastructure, poor housing, lack of sanitation facilities and general state of degradation.

4. A Commission was set up in 1989 to draw up a constitution to lead the country to free elections within the context of a multi-party system in 1992. Once adopted and implemented, it will complete the process of decentralization of power. The lower echelons of this structure, especially the districts, subdistricts and villages, form the basis for community participation in health, water and sanitation projects. As a result of UNICEF advocacy, the Commission is considering including basic children's rights in the Constitution.

5. According to the Population Division of the United Nations Secretariat, Guinea's infant mortality rate (IMR) is 146 per 1,000 live births, and the under-five mortality rate (U5MR) at 248 per 1,000 live births places it among the very high U5MR countries. The three major causes of morbidity recorded in UNICEF-assisted health centres are malaria, diarrhoea and respiratory tract infections, which account for 76 per cent of all under-five illness. At 9 per 1,000 live births, Guinea has one of the highest maternal mortality rates (MMRs) in the world. This is due to a combination of factors, which includes poor pre-natal care and the cultural values among certain ethnic groups that a woman should be able to deliver her baby unaided. Even where health centres exist, women are reluctant to leave their homes to attend pre-natal clinics. It is estimated that 90 per cent of Guinean women undergo harmful sexual mutilations. Goitre and other complications caused by iodine deficiency are very high throughout the country, with the exception of Guinea Maritime. The reported total of deaths caused by acquired immunodeficiency syndrome (AIDS) since 1987 is relatively low. Of those deaths, seven were children below the age of five years. The low figures are explained by the isolation of Guinea until 1985, but there are reasons for concern since there is evidence that the virus has spread throughout the country. A survey by the recently created AIDS Prevention Unit projected 0.9 per cent of the population as being infected with the human immunodeficiency virus (HIV).

6. The scant data available on the nutritional status of children indicate that certain regions are more affected by malnutrition than others. In particular, a recent survey of the Forest Region, where there has been an influx of refugees, showed that 7 per cent of children were affected by severe malnutrition. A preliminary survey at Conakry indicated that 2 per cent of the children are suffering from acute malnutrition, but this figure is likely to be higher as it accounts for 2 per cent of deaths in the city's hospitals. Various surveys are under way that should soon give a better nutritional profile of Guinean children.

7. Guinea is also known as the watershed of West Africa as the sources of the region's major rivers (Niger, Senegal and Gambia) originate from the country. Paradoxically, in spite of this abundance of rivers and streams, only 30 per cent of the rural population had access to safe drinking water in 1989. Although the urban population is slightly better off, with 39 per cent having access to tap water, its quality is not reliable. Sanitation and hygiene are very poor, particularly in urban areas where excreta disposal poses serious health threats to children. In Conakry and the Forest Region, the use of latrines is not considered a hygienic practice. These factors combine to cause a high rate of diarrhoea and other water-borne diseases, except for dracunculiasis (Guinea worm), which, despite its name, appears to have been eliminated.

8. While some progress has been made in the provision of health services and clean water since 1984, the education system remains untouched. Today, the level of illiteracy stands at 74 per cent. The female illiteracy rate is 83.3 per cent, while the rate for males is a much lower 62.2 per cent. In 1987-1988, primary school admission stood at 35.2 per cent, compared with 50.5 per cent in 1984-1985. School attendance is 17 per cent in rural areas. Although 51.3 per cent of the population are females, only 33 per cent of primary

school pupils are girls. Salaries account for 92 per cent of the national education budget, and at Conakry, the teacher/pupil and class/pupil ratios stand at 1:66 and 1:77, respectively. Such a situation is aggravated further by the low quality of the infrastructure, unqualified teachers and lack of teaching materials.

9. Radio reaches less than 20 per cent of the population and television is primarily an urban media. Newspapers are accessible only to a small elite. Hope for the future lies in the establishment of rural radio stations and in the more effective use of traditional channels of communication.

PROGRAMME CO-OPERATION, 1987-1990

10. The overall objective of the programme was to reduce IMR and to raise health and development levels in young children. The programme strategy aimed at improving institutional capacity and upgrading and progressively expanding basic services. The major consideration in the strategy was community participation and management of services, coupled with the efficient use of resources. Close collaboration between UNICEF and other partners constituted the major elements of the country programme strategy.

Health

11. At the start of the programme, health centres attracted only a small percentage of the population because they were in poor condition, underequipped and lacked medical supplies. Less than 10 per cent of the children under one year old were fully immunized against the six expanded programme of immunization diseases. Between 1987 and 1990, UNICEF, in close collaboration with the Government, donor agencies and non-governmental organizations (NGOs), established the basis for a national capacity to plan, monitor and evaluate implementation of the integrated primary health care (PHC) programme. This was achieved through the training of a wide range of health personnel at all levels. In collaboration with the State Secretariat for Decentralization, management committees have been trained to budget and participate in the administration of health centres. This intensive training and other institutional support, combined with the supply of essential drugs and other health materials, have resulted in the revitalization of health centres in 185 out of 350 subdistricts. Thus, about half of the 2,800,000 people living in those areas now have access to quality integrated curative and preventive health care. This includes the immunization of children and women, the protection of pregnant and lactating women, curative care based on essential drugs and growth monitoring of children under five years old. Sustainability is assured by community participation and co-financing using management committees. Regular monitoring and evaluation have shown that health centres are viable provided that support is maintained until a health system is firmly established.

12. Although the integrated approach to providing PHC has made great strides in putting the necessary systems and structures in place, it will take time for universal child immunization to be achieved through improved access to immunization and regained confidence in the health system by the population. The vaccination coverage for the first generation of 98 health centres in 1990 was 60 per cent with

anti-tuberculosis vaccine, 53 per cent with measles vaccine and 35 per cent with three doses each of combined diphtheria/pertussis/tetanus and polio vaccines. Coverage with two doses of tetanus toxoid for pregnant women stood at 45 per cent for 1989. This compares favourably with an average of less than 10 per cent of children fully immunized in rural areas not covered by the programme. The Bamako Initiative offers the perspective for further increasing and sustaining coverage. Conakry, with 19 per cent of the population, experienced a sharp increase of vaccination coverage from 4 to 56 per cent from 1986 to 1987. This declined to 19 per cent when the campaign approach was not sustained. Steps are now being taken to reform the urban health care system according to Bamako Initiative principles in order to ensure more sustained health coverage.

13. The use of oral rehydration therapy (ORT) is estimated at a disappointing 15 per cent, well below the 60 per cent targeted in 1986. The shortfall is due to the insufficient training of paramedical staff and the unavailability of services to 50 per cent of the population, even in areas with revitalized functioning health centres.

14. Low salary levels provoke a lack of motivation of health personnel, making it difficult to recruit health workers for remote areas. This is likely to be accentuated as the programme expands to the periphery. A recent study has shown that 47 per cent of the population live within a radius of 5 kilometres from a health centre, while 89 per cent are within 10 kilometres. Access to immunizations, however, has been increased recently through outreach from health centres.

Water and sanitation

15. UNICEF and other agency assistance in the field of water and sanitation contributed to an increase in the availability of drinking water from 17 to 34 per cent of the population from 1986 to 1989. UNICEF financed the drilling of 225 wells and the capping of 460 springs, benefiting 240,000 people. Institution building, technical assistance and logistics to reinforce the capacity of the Service National d'Aménagement des Points d'Eau (National Water Authority) to train local committees and to maintain and finance repairs of water points were also provided. Some 200 demonstration latrines have been constructed near health centres, schools, mosques and other public places with the support of a health education programme. While communities have participated readily in the water programme, involvement in sanitation projects has been more difficult to obtain. However, the current programme has laid the necessary base for a more effective sanitation intervention in the future.

Basic education

16. Effective UNICEF assistance in this sector began only in 1989 with the development of a national education policy. Technical assistance was provided to literacy, child-to-child and early childhood development programmes, and some 200 teachers and aides were trained in 10 experimental schools. A feasibility study will determine the viability of going-to-scale in the next programme of co-operation.

Decentralization and micro-projects

17. This programme aimed at reinforcing the capacity of the Department of Decentralization to develop a national strategy for micro-projects and to create a fund to finance small projects benefiting women. Some 100 staff at national, regional and prefectoral levels were trained in planning and monitoring micro-projects. It has also assisted NGOs involved in household food security for 1,000 families and supported 26 small income-generating projects benefiting 600 families. Moreover, it has been catalytic in encouraging the United Nations Development Programme (UNDP), IBRD, the United States Agency for International Development (USAID), the Canadian International Development Agency (CIDA) and other donors to participate in the programme. UNICEF advocacy efforts have culminated in the creation of a local development project fund for micro-projects as an incentive for community participation.

Social dimension of adjustment

18. UNICEF provided technical assistance to an intersectoral working group on mitigating the impact of structural adjustment. This has led to the creation of a unit responsible for monitoring and evaluating the social impact of adjustment and recommending mitigating actions. UNICEF participation has decreased during the latter part of the programme, but steps have now been taken to use this unit as an additional channel to monitor and advocate on behalf of mothers and children.

Emergency assistance

19. The influx of 80,000 refugees at the beginning of the civil war in Liberia in early 1990 increased to some 300,000 by mid-1990. UNICEF and the European Economic Community (EEC) were the first multilateral organizations to respond to the emergency by providing essential drugs, vaccines and logistical support through Médecins Sans Frontières (Doctors without Borders) (Belgium). Further assistance was provided by protecting water points, drilling wells, constructing latrines and through health education. In addition to a swift response, UNICEF was catalytic in successfully advocating for assistance to both refugees and the local population who have generously shared their food and shelter with them. EEC and the Office of the United Nations High Commissioner for Refugees (UNHCR) have joined with UNICEF in providing 60 wells that will continue to serve the local population after the departure of refugees.

Lessons learned

20. The main strength of the Guinean programme is the result of government adherence to a process of adjustment with a human face, which, combined with a policy of participatory development, has created a climate conducive to the adoption of child survival and development (CSD) strategies. This opportunity has been seized to establish a co-financed and co-managed community recovery health care system and a water programme based on decentralization through community involvement. The results have clearly demonstrated that such an approach is not only feasible, but economically viable and expansion sustainable, even in a country with serious structural inadequacies, provided certain basic conditions are met.

In particular, it has required a considerable investment in human resources to build the necessary capacity at national, regional, prefectoral and sub-prefectoral levels. It has also demonstrated the need for constant monitoring and evaluation, not only to enable corrective measures and adjustments to be undertaken, but also as an important means of motivating all the participants involved in the process.

21. While the Government has adopted the appropriate CSD policies, such as the ratification of the Convention on the Rights of the Child, this commitment has not always been matched by the required resources being put at the disposal of the ministries involved in their implementation. Furthermore, constant advocacy at all levels is required to ensure that the necessary mechanisms are put in place to decentralize and transfer management control of health care to the community.

22. Programmes have been utilized where there is a felt need, such as in the provision of curative health care and the supply of clean water, and in the future, particular attention must be given to areas such as preventive medicine and sanitation where the causes and effects are not apparent. This is a major new programme challenge that has been responded to by strengthening social mobilization and health education to ensure that the long and arduous task of changing attitudes and practices is embarked upon in earnest. In this context, a CSD action group was set up to promote action for children. Past experience has shown that advocacy is a continuous process involving keeping abreast of events in order to seize upon the appropriate occasions to influence policies, change attitudes and generate action in favour of women, children and other vulnerable groups.

RECOMMENDED PROGRAMME CO-OPERATION, 1991-1995

Recommended general resources: $ 9,250,000
Supplementary funding: $15,250,000

Recommended programme co-operation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health and nutrition	3 900	6 155	10 055
Water supply, sanitation and primary environmental care	2 250	6 245	8 495
Education for all	1 350	1 100	2 450
Social mobilization and advocacy for child survival	1 100	700	1 800
Urban development	650	1 050	1 700
Total	9 250	15 250	24 500

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programme goals and objectives

23. The main objective of the 1991-1995 programme of co-operation will be to support the implementation of government policies aimed at ensuring the survival, development and protection of children and mothers. An assessment of these policies, in conjunction with the strategies for children in the 1990s, has led the Government and UNICEF to adopt the following goals: (a) to reduce IMR to 100 per 1,000 live births, U5MR from 248 to 150 per 1,000 live births and MMR from 900 to 750 per 100,000 live births by 1995; (b) to provide 90 per cent accessibility to PHC services by 1995; (c) to ensure that 60 per cent of the rural population have access to 10 litres of safe drinking water per capita per day by 1995, combined with sanitation education; (d) to improve the quality and relevance of primary school curricula and learning materials, to assist in increasing school attendance from 28.6 per cent in 1989 to 40 per cent in 1995 and to reduce illiteracy from 74 to 60 per cent in 1995; and (e) to strengthen information channels to ensure that 75 per cent of all Guineans are aware of CSD skills and services.

Programme strategy

24. The strategy aims: (a) to advocate and carry out social mobilization activities to create a climate that is conducive to concrete actions for the survival, development and protection of children; (b) to consolidate the achievements of the previous programme of co-operation by increasing coverage effectiveness; (c) to support the decentralization process to ensure community involvement; and (d) to reinforce and upgrade national capacity, combined with effective community participation, to ensure sustainability.

Health and nutrition through the Bamako Initiative

25. The achievements of the programme of integrated PHC based on the Bamako Initiative will be consolidated and expanded both geographically and in scope. By the end of 1995, 90 per cent of the population will be covered by an integrated health programme that will provide pre- and post-natal care, immunization, the control of diarrhoeal diseases and essential curative care linked to nutrition, education, water and environmental sanitation activities. Within the subdistricts with functioning health centres, access will be increased from the current 47 to 90 per cent of the population and systems will be put in place to monitor and increase utilization of existing services. In addition, at least one health centre in each of the remaining subdistricts will be operationalized.

26. To consolidate the achievements to date, continued strengthening of institutional support through a system of community participation is needed. The efficiency of the services will be improved by more rigorous management, with particular attention being paid to the preparation and execution of health centre budgets and the rationalization of services offered. This will involve regular monitoring, evaluation and operational research. Particular attention will be paid to the financial viability of the programme through community co-financing. The implementation of the co-financing system for the first generation of 98 health centres shows that they are now in a position to start paying for their essential drugs and that the 79 second-generation centres should be in a similar position after two years of operation. However, logistical support, equipment and other materials will be required for a longer period of time. The low quality of referral infrastructures indicates that some technical and material assistance in this area will contribute to reaching adopted objectives.

27. Immunization and ORT will continue within the context of the integrated PHC system. The objective will be to increase and maintain immunization coverage at 75 per cent by 1995 for all antigens. This will be achieved by increasing the availability of centres, as well as through better training and mobilization of both health workers and the population to ensure daily vaccination services and full contact opportunities. As the current low vaccination coverage is mainly due to the high proportion of defaulters, the baby tracking system will be reinforced through the establishment of a community-based monitoring system. Although ORT is part and parcel of the integrated PHC system, its use nationally as a treatment for diarrhoeal dehydration amounts to only 15 per cent as a treatment. This component aims to reduce infant mortality caused by diarrhoeal dehydration through the correct administration of ORT in 80 per cent of child diarrhoea cases by 1995. To

achieve this objective, the education of health personnel in the programme will be strengthened, and there will be increased social mobilization activities. Steps will also be taken to involve traditional birth attendants (TBAs) in the use of ORT. Discussions are under way to initiate a joint ORT promotion programme with Population Services International, thus complementing the work currently being undertaken by USAID/Combating Communicable Childhood Diseases (CCCD).

28. Maternal health care will be reinforced by the training of an additional 3,500 TBAs in safe delivery skills. Some 350 midwives will be trained to ensure the proper training and monitoring of TBAs and to increase awareness of risk pregnancies, maternal health care, birth spacing and family planning. UNICEF will co-operate with other donors to renovate and upgrade maternal and child health wards at each of the district referral hospitals. A major social mobilization exercise will be launched to increase the number of pregnant women attending pre- and post-natal clinics to 80 per cent, to change traditional attitudes and practices that are detrimental to safe delivery and to increase awareness of the dangers of the HIV virus.

29. With regard to nutrition, emphasis will be placed on promoting prolonged breast-feeding, which is currently practised by 70 per cent of Guinean women. Since reports from health centres show that infants experience growth problems from six months onwards, rapid assessment procedures/knowledge, attitude and practice (RAP/KAP) studies will be undertaken to determine the specific local causes and actions will be programmed accordingly. Although the extent of malnutrition is difficult to quantify, the scant data available suggest that it is a problem that requires attention. A clearer picture will emerge once preliminary results of various studies currently under way become available, and these will be used to design preventive nutrition interventions. Particular attention will be paid to growth monitoring and promotion through community participation, using mothers as weight watchers as an integral part of the PHC system. The problem of iodine deficiency is evident by the large number of women with goitre throughout the country, except in Guinea Maritima. This situation was confirmed in a recent study by the Pasteur Institute, which showed that in some villages, 70 per cent of the population suffered from this micronutrient deficiency. A project is being prepared with the Government to identify the areas affected and to select various options to provide iodine supplements.

Water supply, sanitation and primary environmental care

30. UNICEF will continue its close collaboration with the Service National d'Aménagement des Points d'Eau and donor agencies in order to improve water supply and environmental sanitation. This assistance will aim to reinforce the capacity of the Service to plan, execute, monitor and evaluate rural water projects. It will also assist in the establishment of a system to control the quality of drinking water. Emphasis will be placed on technical and logistic assistance to the Service's Division of Maintenance, especially to inform and motivate the target population and to ensure community participation in the protection and upkeep of water points. This programme will assure clean drinking water for 390,000 people, or an additional 9.4 per cent of the rural population. Steps will be taken to obtain World Health Organization (WHO) confirmation that dracunculiasis has been

eradicated nation wide. In the area of sanitation, the main objective will be to build demonstration latrines in 120 health centres, 100 schools and 6 public places and to guarantee their proper use and maintenance through community participation and health education. The primary environmental care component is experimental, linked closely to the water and sanitation programme, and aims to protect the immediate environment through community actions.

Education for all

31. The programme will support government efforts to increase the school attendance rate and its literacy programme. It will also support six experimental community projects through which children both in and out of school can acquire life skills. This approach is necessary to complement the efforts of various donors by increasing the absorption capacity of the Department of State for Pre-University Education and by developing new approaches to basic education. This supportive role is essential as various donors, in particular USAID, IBRD and the Governments of Canada and Japan, have agreed to support basic education projects. This will be done with technical assistance to increase the ability of the Department to plan, execute and monitor projects. It will also support department efforts to strengthen data collection and analysis. A project aimed at early childhood education through community participation will be put into place. The necessary structures and systems for the care of 100,000 pre-school children through 500 child-care community groups will be set up. UNICEF support of functional literacy will provide 350,000 women and girls with the training needed to enable them to acquire basic skills at 350 experimental functional literacy centres, promoting research and action to enhance their living conditions and those of their children.

Urban development

32. The poor environmental conditions of 75 per cent of Conakry's population living below the poverty line demand concerted action by the Government, the local administration, religious leaders, NGOs and donor agencies. UNICEF will work closely with all those partners to improve the situation. In particular, it will reinforce the large urban projects being implemented with actions at the local level to ensure community participation to mitigate the negative social effects of capital intensive urban projects. In close collaboration with the Ministry of Urban Planning and other UNICEF programmes in health, education, water and sanitation supported by social mobilization, UNICEF will promote an integrated approach for providing basic services at the community level. The success of such an approach can serve as a model for wider use.

Emergency response to children in difficult circumstances

33. The influx of 300,000 Liberian refugees has enabled UNICEF to gain experience in emergency situations that can be used to protect women and children in Guinea. Such situations call for quick, concerted action with the Government and various international agencies. UNICEF programmes in health/nutrition and water and sanitation give an on-the-spot capacity to react promptly to emergencies. Monitoring capacity to assess the impact of any emergency on the health and

nutritional status of mothers and children will be maintained to enable the necessary corrective actions to be taken.

Advocacy and social mobilization

34. Social mobilization is an essential process that will be fully exploited to ensure that transmitted messages result in concrete actions for CSD. It is imperative that this mobilization utilizes all means and methods of communication, in particular traditional and interpersonal channels. This approach is even more important because the modern media is accessible to less than 20 per cent of the population. This approach will increase the utilization of health centres for preventive care, as well as the level of school attendance in general and of girls in particular. It will also ensure a more effective use of water points and sanitation facilities. Ultimately, social mobilization will be used to obtain the synergistic benefits of UNICEF programmes in Guinea to ensure that at least 75 per cent of the population is informed and utilizes the CSD services provided.

Monitoring and evaluation

35. A co-ordination commission will be created to monitor programme implementation. An annual review will be undertaken during the last quarter of each year to examine implementation of the annual current plans of action and approve those for the coming year. Programme evaluation will be based on regular monitoring and evaluation reports, data from the National Information and Statistics System and from RAP/KAP studies. There will be a mid-term review in 1993, and a final evaluation of the country programme will be undertaken in 1995. Continuous updating of the situation analysis will permit the regular publication of sectoral monographs, as well as a revision of the situation of women and children in Guinea in 1994.

Co-operation with the United Nations and other organizations

36. UNICEF will continue to work closely with other agencies to achieve the national goals for the 1990s. In particular, the health and nutrition programme requires close collaboration with WHO, the United Nations Population Fund (UNFPA), the World Food Programme (WFP), UNDP, IBRD, AfDB, the German Agency for Technical Co-operation, CCCD and NGOs such as Médecins Sans Frontières (Belgium), Medicus Mundi and Grupi Volontari Civili (Italy). Similarly, the water and sanitation programme is financed jointly by EEC, the Islamic Development Bank, IBRD and UNHCR (in refugee areas). In the education programme, the main partners will be USAID, CIDA, IBRD, the Japan International Co-operation Agency and the United Nations Educational, Scientific and Cultural Organization (UNESCO). Now that IBRD and UNDP are financing micro-projects, past UNICEF experience will make a useful contribution to increase the chances of success of these interventions. Regular contacts will be maintained with other donors and visiting missions to ensure complementarity of action.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Guinea (1989 and earlier years) — UNICEF country classification

Under-five mortality rate	241	(1989)	Very high U5MR
Infant mortality rate	142	(1989)	Very high IMR
GNP per capita	$ 430	(1988)	Low GNP
Total population	6 million	(1989)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1989
Births	(thousands)	210	227	251	278
Infant deaths (under 1)	(thousands)	38	37	38	39
Under-five deaths	(thousands)	65	62	65	67
Under-five mortality rate (per 1,000 live births)		309	275	260	241
Infant mortality rate (under 1) (per 1,000 live births)		182	162	151	142

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1987)	Moderate & severe	..	..
	Severe	..	..
Babies with low birth weight (%, 1979/1987)		18	25*
Children completing primary level (% of first grade, 1980/1986)		..	70

NUTRITION INDICATORS	About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1986)	100*/ 70*/ 40*	100*/ 90*/ 85*
Prevalence of wasting (%, 1980/1985)	..	..
Prevalence of stunting (%, 1980/1985)	..	..
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)	79	77
Food production per capita index (Index 1979-1981=100, 1980/1989)	102	88
Household expenditure (% of total income, 1980-1985) — All food/cereals		../..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1987-1988)			1
Access to health services (% of population, 1980/1985)	Total	..	47
	Urban/rural	../..	100/ 40
Access to safe water (% of population, 1980/1985)	Total	17	38*
	Urban/rural	69/ 2	65*/ 30*
Access to adequate sanitation (% of population, 1980/1987)	Total	14	..
	Urban/rural	54/ 1	../..
Births attended by trained personnel (%, 1980/1988)		..	25
Maternal mortality rate (per 100,000 live births, 1979/1987)		..	800*

Immunization		1981	1985	1988	1989
One-year-olds (%) immunized against:	Tuberculosis	4	..	31	..
	DPT	..	..	16	..
	Polio	..	..	16	..
	Measles	15	4	27	..
Pregnant women (%) immunized against	Tetanus	5	5	6	..

/...

TABLE 1 (continued)

Guinea

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%, 1980/1988)	Total	32/ ..	30/ 23
	Male	42/ ..	42/ 31
	Female	21/ ..	19/ 15
Secondary enrolment ratio (gross/net) (%, 1980/1988)	Total	14/ ..	9/ 6
	Male	21/ ..	13/ 9
	Female	8/ ..	4/ 3
Adult literacy rate, 15 years & older (%, 1970/1985)	Total	14	17
	Male/female	21/ 7	26/ 8
Radio/television sets (per 1,000 population, 1980/1988)		30/ 1	34/ 3

DEMOGRAPHIC INDICATORS		1970	1980	1985	1989	2000**
Total population	(millions)	3.9	4.5	5.0	5.6	7.8
Population aged 0-15 years	(millions)	..	2.4	2.4	2.7	4.1
Population aged 0-4 years	(millions)	..	0.9	1.0	1.1	1.6
Urban population (% of total)		14	19	22	25	33
Life expectancy at birth (years)	Total	37	40	42	43	48
	Male	36	39	41	43	47
	Female	37	40	42	44	48
Total fertility rate		7.0	7.0	7.0	7.0	6.8
Crude birth rate (per 1,000 population)		52	51	51	51	49
Crude death rate (per 1,000 population)		28	25	23	22	18

		About 1980	Most recent
Contraceptive prevalence rate (%, 1976/1987)		1	..
Population annual growth rate (%, 1965-1980/1980-1989)	Total	1.9	2.5
	Urban	6.6	5.6

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1988)		1.3	..
Inflation rate (%,1965-1980/1980-1988)		3	..
Population in absolute poverty (%,1977/1988)	Urban/rural	../..	../ ..
Household income share (%,1977/1988)	Top 20%/bottom 40%	../..	../ ..
Government expenditure (% of total expenditure, 1980/1987)	Health/education	../ ..	3*/ 11*
	Defence	..	29*
Household expenditure (% of total income, 1987)	Health/education		14*/ 1*
Official development assistance: (1980/1988)	$US millions	90	262
	As % of GNP	6	11
Debt service (% of goods & services exports, 1980/1988)		..	22

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1987-1990

(In thousands of United States dollars)

COUNTRY: GUINEA
LATEST BOARD APPROVAL: 1987
GENERAL RESOURCES: $5,765,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	867	936	92	323		563	255	1249	1214	3071	4285
Water supply and sanitation	1579		51		126		184		1940		1940
Nutrition			4				2		6		6
Education	62		26		14		150		252		252
Community organization and development	111		57	20			150	42	318	62	380
Women-centred programme	30		15				5		50		50
Planning and project support	159		6		900		408	3	1473	3	1476
Freight	177	5							177	5	182
GRAND TOTAL	2985	941	251	343	1040	563	1154	1294	5430	3141	8571

GR = General resources.
FSF = Funded supplementary funding.

TABLE 3. PLANNED EXPENDITURE, 1991-1995

(In thousands of United States dollars)

Country: GUINEA Period covered: 1991-1995	Funding status	1991	1992	1993	1994	1995	Total
Health	GR	830	830	780	730	730	3900
	FSF	1822					1822
	NSF	1025	1625	1325	1310	870	6155
Water supply and sanitation	GR	450	450	450	450	450	2250
	NSF	450	1650	1500	1400	1245	6245
Education	GR	250	250	250	300	300	1350
	NSF		200	300	300	300	1100
Social mobilization and advocacy	GR	220	220	220	220	220	1100
	NSF	50	150	150	150	200	700
Integrated area-based programme	GR	100	100	150	150	150	650
	NSF	100	200	250	250	250	1050
TOTAL	GR	1850	1850	1850	1850	1850	9250
	FSF	1822					1822
	NSF	1625	3825	3525	3410	2865	15250
GRAND TOTAL		5297	5675	5375	5260	4715	26322

GR = General resources.
NSF = New supplementary funding.
FSF = Funded supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: GUINEA	Number of posts	Amount (thousands of United States dollars)
FINANCED FROM 1992-1993 PROPOSED BUDGET:		
International Professional established posts	3	671
Local national Professional and General Service established posts	6	301
Operating costs		734
Total	9	1706
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	3	655
Supplementary funds	2	452
Local national Professional and General Service project posts		
General resources	18	605
Supplementary funds	7	202
Total	30	1914

a/ For information source, see 1992 post authorization table, dated January 1991.

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UNITED NATIONS CHILDREN'S FUND
Programme Committee
1991 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Nigeria

The Executive Director recommends that the Executive Board approve the country programme of Nigeria for the period 1991 to 1995 in the amount of $65 million from general resources, subject to the availability of funds, and $60 million in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1990, will be contained in the "Summary of 1991 recommendations for general resources and supplementary funding programmes" (E/ICEF/1991/P/L.2).

** Expenditure for the period 1986-1988 was previously included in document E/ICEF/1989/P/L.8.

THE SITUATION OF CHILDREN AND WOMEN

1. Nigerian children account for one out of every five born in Africa. The country is potentially one of the richest in the continent. Its large land area is suitable for many agricultural and forestry products, and oil and gas account for over 90 per cent of its foreign exchange earnings. The urbanization ratio rose from 19 to 33 per cent between 1963 and 1989, but most Nigerians still live in rural communities of less than 20,000 inhabitants each. Women and men working an average of 2.5 hectares per household produce over 90 per cent of food needs. The informal sector provides at least one half of urban employment and a large part of rural income. The Government-projected 1990 population of 115.4 million consists of ethnic groups ranging in size from a few thousand to many millions. Over 250 languages are spoken and there are roughly equal numbers of Moslems and Christians.

2. The country consists of a federal capital territory and 21 states divided into 453 local government areas, which have elected chairmen and an average population of 245,000. The three separate, but interlocking, levels of government have independent budgets. The federal Government is responsible for national concerns such as defence. Aided by the states, local government areas implement development programmes in agriculture, provide primary and adult education and primary health care (PHC). The federal Government sets sectoral priorities while local governments implement programmes. Traditional rulers remain the most influential local leaders. Nigeria has been under military rule almost continuously since independence in 1960. In 1992, the country will return to an elected civilian Government.

3. The 1970s oil boom allowed for large investments in economic infrastructure and social services. The fall in the price of oil reduced annual foreign exchange earnings from $24 billion to $6 billion between 1981 and 1985. The Government started a structural adjustment programme (SAP) in 1986. While the programme has restrained negative growth rates and improved the balance-of-payments position, annual per capita gross national product (GNP) fell from $640 in 1986 to about $250 by 1989. Formerly classified as middle-income, Nigeria is now a low-income country. Debt rescheduling has lowered interest repayments, but total debt rose from about $18 billion to over $30 billion in 1990.

4. Federal health allocations fell from 6.8 to 1.5 per cent of the total budget between 1986 and 1990. Education receives just over 3 per cent of the budget. Real wages declined by almost 50 per cent and the yearly inflation rate reached 45 per cent between 1987 and 1989. A growing proportion of households has difficulty in meeting basic needs. Malnutrition and unemployment have increased. Enrolment in primary schools declined from 89 to 62 per cent during the 1980s, with the largest decline among girls. Recent surveys by the University of Ibadan found that in five local government areas the proportion of severely malnourished children rose from 9 per cent in 1987 to 14 per cent in 1990. Over 5 million babies are born every year, but one out of seven dies before the age of five. About 50 per cent of the population

has access to modern health care services. Essential drugs are expensive, frequently out of stock, fake or expired. Trained health personnel attend only 40 per cent of deliveries. Only 22 per cent of rural dwellers have adequate supplies of household water. Unsafe waste disposal methods are widespread and increase the risk of life-threatening infections. The average Nigerian child between the ages of 6 and 24 months experiences 4.3 episodes of diarrhoea per year. Despite the emphasis placed on education, literacy rates are 55 per cent for males and 31 per cent for females. National figures do not reflect disparities among regions and socio-economic groups.

5. Life expectancy at birth has risen from 35 years in the 1960s to 54 years in 1989. The Government estimated the 1989 infant mortality rate (IMR) and under-five mortality rate (U5MR) at 85 and 145 per 1,000 live births, respectively. Eighteen per cent of newborn babies have low birth weights. The main causes of childhood mortality and morbidity are malaria, diarrhoeal diseases, acute respiratory infections (ARI), vaccine-preventable diseases and illnesses related to poor nutrition. Intestinal parasites, skin infections, meningitis, yellow fever, onchocerciasis (river blindness) and dracunculiasis (guinea worm disease) are also common. Onchocerciasis affects about 6 million people, while dracunculiasis affects 650,000 people annually, 60 per cent of the global total. The number of confirmed cases of acquired immunodeficiency syndrome (AIDS) is still low, but rising.

6. Women produce much of the country's food, but many mothers are overworked, illiterate, poorly nourished and without means of earning an adequate income. More than one half of all marriages involve girls under the age of 18 years. Total fertility is 6.3 children per woman. Repeated pregnancies at short intervals and until an advanced age increase the risks of complications in pregnancy and childbirth. Poor nutrition, anaemia, inadequate antenatal and postnatal care and low literacy also raise maternal mortality rates (MMRs), which recent government surveys put at about 1,500 per 100,000 live births. Underaged and undereducated girls look after younger children. Boys and girls spend hours fetching firewood and water, selling items in the market and looking after livestock. Their dietary intake is inadequate in energy and crucial nutrients. Feeding practices make little allowance for the needs of young children and pregnant women. Breast-feeding often ceases suddenly during the early part of the second year of life.

7. The Government has adopted a health policy based on PHC, created an agency for mass mobilization and political education, which also promotes child survival, and produced a blueprint on mass literacy. It has set up directorates for employment and food, roads and rural infrastructure and a commission for women. The Persian Gulf crisis has increased oil revenues. The debt burden will fall and the country can avoid disruptions to economic reforms. The medium-term economic outlook is brighter now than at any time since the late 1970s. However, the gap between requirements and the availability of funds has widened. In many sectors, the ratio of operational expenses to personnel costs is deteriorating. Many local government areas face difficulties in providing equipment and maintaining buildings for social services. Salaries and related costs claim between 90 and 95 per cent of all

health expenditures. Even if annual growth rates for the economy (4 per cent) and population (3.3 per cent) remain constant, many Nigerian children and women will continue to suffer from malnutrition and remain vulnerable to preventable threats to their survival and development.

PROGRAMME COOPERATION, 1986-1990

Health

8. The expanded programme on immunization (EPI) and oral rehydration therapy (ORT) were the main elements of early PHC activity in Nigeria. The country launched a revised EPI in 1984 and ORT in 1985. In 1986, the Government allocated $100 million for the phased introduction of PHC. Both EPI and ORT were, and still are, key elements in the reorientation of a health system that previously concentrated on curative services. Since 1986, the programme of cooperation aimed to establish them throughout the country and achieve universal child immunization (UCI). It also included state- and local government area-based projects in water supply and sanitation, integrated community health, early child care and household food security and nutrition.

9. EPI assisted in building an infrastructure at all levels. By mid-1987, EPI was functioning in all local government areas, but coverage was behind target. Many children and pregnant women remained inaccessible and default rates were high. Non-governmental organizations (NGOs) encouraged the Government to organize a series of nine immunization days over three consecutive months in 1988. Advocacy and social mobilization led to a high level of political and budgetary commitment. Eighteen million vaccinations were administered in nine days. In 1989, most States organized their own immunization days. In 1990, the local government areas followed suit with local, district and village immunization days. EPI coverage rose from about 5 to over 60 per cent between 1984 and mid-1990. Tetanus toxoid vaccine will now cover all women of child-bearing age. EPI will soon include yellow fever and cerebro-spinal meningitis immunizations.

10. There is cautious optimism that the country will reach UCI. It is estimated that over 103,000 EPI disease-related deaths were prevented in 1989. EPI has helped to introduce effective managerial processes for improved service delivery. It has strengthened community involvement and cooperation with NGOs. Widespread training, followed by field supervision, has improved the skills of many health staff. Rapid acceleration has narrowed the imbalance between urban and rural areas. The major priority now is to provide daily EPI services as an integral part of PHC and to sustain the achievements of rapid acceleration.

11. The ORT programme assisted the Federal and state governments in establishing systems for ORT promotion at all levels. A national ORT policy was introduced based on the treatment of dehydration by oral rehydration at first referral level and prevention with sugar-salt solution at home. The programme developed high-quality ORT training materials and modules. Over

3,000 ORT units and three national diarrhoea training units are now functioning across the country. Advocacy for political and professional support for diarrhoea control using ORT has been effective. The Federal Minister of Health has instructed states and local government areas not to use government essential drug funds to buy anti-diarrhoeals. The programme succeeded in reducing hospital admissions, the costs of treatment and diarrhoea fatality rates. According to the 1989 in-depth review, the number of deaths attributable to diarrhoea has fallen by 50 per cent since 1986, from 200,000 to 100,000 every year. There are still some 4.3 episodes per year for children between the ages of 6 and 14 months. Considerable effort will be needed if Nigeria is to reach targets of 80 per cent public awareness and 60 per cent practice of ORT.

12. UNICEF worked with the Federal Ministry of Health to develop models for integrated basic services in four of the initial 52 PHC model local government areas. In addition to the eight normal components of PHC, local government areas introduced household food security and nutrition and early child-care development and education. Staff, voluntary health workers and traditional birth attendants (TBAs) underwent training and reorientation in all aspects of PHC. All local government areas in the programme have launched growth-monitoring activities. With Benin and Guinea, Nigeria has been among the pioneers in adopting the Bamako Initiative as a means of accelerating PHC development. The Ministry allocated $2 million for the introduction of the Initiative strategy to revitalize maternal and child health (MCH) and strengthen community participation in four local government areas. Participating States received a World Bank loan for drugs at tertiary and secondary levels. Health staff underwent training in procurement, distribution, cost-sharing and monitoring systems. This led to increased dynamism in village PHC committees, better financial management and greater community participation in health. In addition, PHC is receiving growing political and financial support in the pilot areas. Participating local government areas have achieved high EPI coverage levels. The programme has also strengthened the health information system and planning, monitoring and evaluation. In 1990, the Bamako Initiative approach was implemented in eight other local government areas.

13. Over the last five years, EPI and ORT have contributed to the rapid building of a health infrastructure and delivery systems that will be central to continuing attempts to reduce morbidity and mortality rates. In concert with state governments, and in line with the current emphasis on decentralization, the Ministry recently issued directives that give local government areas total jurisdiction over PHC in their areas beginning in 1991. Many programmes have reached a critical mass of infrastructure and mobilization and gained enough confidence to make a transition to locally managed service delivery, with an emphasis on community participation and sustainability. The greatest need is to strengthen the management of health care delivery at the community level.

14. The programme included household food security and nutrition activities in selected local government areas in different states. The aim was to design and test a model food and nutrition promotion strategy that can be replicated in PHC programmes. The projects follow an intersectoral approach that includes community mobilization, advocacy training and monitoring. After the introduction of improved varieties of planting materials, groups of women farmers underwent training in food processing, storage and marketing technologies. The project helped the groups to gain greater access to land, credit and extension services. Over 11,000 farmers and many women's groups, schools, mosques and churches in the five local government areas have so far received improved cassava varieties, soybean seeds and oil-palm seedlings. Women's nutrition status and access to income have improved. The challenge has been to maintain the balance between food production, income generation and nutrition promotion. Although growth monitoring in developing countries started in Nigeria, there has been only limited application of the approach. Health centres with growth-monitoring activities fail to use the results to involve communities in food and nutrition activities.

Water supply and sanitation

15. Before 1986, national water supply policies excluded sanitation and small rural communities, where about 60 per cent of the population live. The programme assisted six states to carry out health-focused programmes to provide hand-pump equipped boreholes linked with ventilated improved pit latrines and backed up by the deployment of village-based workers. State governments paid recurrent costs, while UNICEF supplied foreign exchange inputs and technical assistance. The programme also assisted the Federal Ministry of Health to improve water supply and sanitation at rural health clinics in 52 local government areas. The programme benefited 1.5 million people and completed 3,000 hand-pump-equipped boreholes and developed five gravity-fed springs. It set up four central state maintenance workshops and trained 200 hand-pump maintenance mechanics. A 1988 impact evaluation found that the project had saved women and children much time in water collection. It found significantly greater decreases in the prevalence of wasting among children under three years old and of dracunculiasis in the intervention area than in the control area. The Government has devoted considerable resources to replicating the approach nationally through the Directorate of Food, Roads and Rural Infrastructures. In spite of these achievements, national access to rural water supply remains low. Having replicated the experience of pilot local government area activities in six states, the priority now is to consolidate the approach.

Advocacy, social mobilization and external relations

16. In such a large and diverse country, advocacy and social mobilization are central to child survival strategies. Extensive high-level advocacy, supported by capacity-building in the Nigerian media, played a major role in the country programme. The Nigerian Television Authority set up a child survival and development (CSD) secretariat. All 21 state branches of the national television and 19 state and national radio stations created

production units for child survival programmes. In 1988, six major NGOs with about 3 million members began mobilizing parents and children for EPI. The newly created Better Life for Rural Women, led by the First Lady, as well as Nigerian artists and intellectuals, joined the drive for CSD. Health educators have played a role in areas beyond the reach of the media.

17. Many political and community leaders, as well as government and non-governmental agencies, have joined a growing coalition for child survival and have shown a high level of commitment. UNICEF-assisted programmes in health, water supply and sanitation and household food security and nutrition have received significant allocations of scarce local resources. The Government and NGOs also contributed directly to supplementary funds in both local currency and in United States dollars. This amounted to an average of approximately $4 million over each of the past three years. Additionally, the reimbursable procurement system enabled state health ministries to buy about 35 per cent of the offshore EPI supplies. Nigeria is among the few developing countries buying most of its own vaccines.

Planning, monitoring and evaluation

18. External and internal evaluations included assessments of the cost-effectiveness, coverage and impact of immunization, the effectiveness of integrated basic services, the impact of social mobilization strategies and the situation of street children. UNICEF began to assist the Government to monitor the social impact of SAP. UNICEF also worked with national statistical and research agencies, universities and professional associations to develop indicators for the situation of children and women.

19. The preparation of the 1991-1995 country programme involved the collection of information on socio-economic conditions of children and women nationally and in eight states. This included a rapid survey of households in order to fill data gaps. It led to the establishment of one national and eight state task forces on the situation of children and women. The launching of the state and national situation analysis reports provided an opportunity to publicize the Convention on the Rights of the Child. In preparation for the World Summit for Children, a seminar was held in which discussions centred on the Convention.

RECOMMENDED PROGRAMME COOPERATION, 1991-1995

Recommended general resources: $65 000 000
Supplementary funding: $60 000 000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	24 813	24 979	49 792
Water supply and sanitation	13 650	12 220	25 870
Household food security and nutrition	7 627	9 921	17 548
Basic education	10 943	10 298	21 241
Children in especially difficult circumstances	471	793	1 264
Advocacy and social mobilization	3 254	1 000	4 254
Planning, monitoring and evaluation	4 242	789	5 031
Total	65 000	60 000	125 000

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programme objectives

20. The objectives are derived from a synthesis of the priorities of the national rolling plan, 1990-1992, and the global goals and strategies for children and development in the 1990s. The programme will increase access to PHC, promote widespread rural water supply and sanitation coverage, improve nutritional practices and strengthen basic education.

21. The national outcome objectives of the programme for the period 1991-1995 are to reduce: (a) IMR by 25 per cent; (b) U5MR by 15 per cent; and (c) MMR by 15 per cent. In eight focus states, with a total population of 38.7 million, the goals are to reduce: (a) IMR by 30 per cent; (b) U5MR by 20 per cent; and (c) MMR by 20 per cent. In two urban local government areas,

the goal is to improve the survival, protection and development of children in especially difficult circumstances.

Programme strategy

22. The country programme will provide a framework through which the Government and UNICEF will support interrelated programmes, projects and activities in different sectors and at federal, state and local levels. The strategy takes into account the goals contained in the Summit Plan of Action and is based on four central concepts: reaching vulnerable and inaccessible groups; preventing and treating those diseases that are responsible for most of the ill-health and deaths in communities; stressing community involvement based on a high level of awareness; and reducing geographical and gender disparities.

23. The programme will aim to remove obstacles to the survival of children and women by focusing on service delivery at the community level, supported by effective planning, budgeting, management, supervision and monitoring of programmes to address the underlying causes of problems affecting most of the population. In all projects, the programme will develop and test delivery strategies and management systems, as well as train field staff as a means of strengthening institutional capacity. It will strengthen the capacity of health, education and other services to make use of modern techniques for reaching as many people at as low a cost as possible. The dissemination of information and knowledge, using Facts For Life, will be a priority. The coalition of agencies involved in the programme will be broad enough to ensure that interests not conventionally associated with health become involved in CSD. Basic education and literacy for girls and women will receive renewed emphasis.

24. Since the beginning of the 1980s, successful UNICEF-assisted local government area models in different sectors have been replicated on a larger scale. The Government and UNICEF have agreed that EPI, ORT and the control of diarrhoeal diseases (CDD), advocacy and social mobilization, and monitoring and evaluation will continue at the national level. Because of limited UNICEF resources, however, the Government has decided that the programme should assist eight states containing 155 of the 453 local government areas so as to develop models for integrating child survival initiatives with basic service delivery. The focus States are Bauchi, Benue, Cross River, Gongola, Kaduna, Niger, Ondo and Oyo. They contain 38.7 million people, about one third of the national population. Selection criteria included geographical and ethnic spread, the degree of commitment to PHC and the possibility for disparity reduction.

25. National projects will consist of activities with the federal and all state governments. Subnational projects will operate in the focus states and support state-wide initiatives in 155 local government areas and community activities in 46 model local government areas. In 1991, projects will start in 16 local government areas where PHC implementation is most advanced, where there is momentum for a reorientation of community-level services. In 1992

and 1993, an annual target of 15 additional local government areas will receive assistance, thus allowing the states to complete PHC introduction in all local government areas. Local government areas with low coverage of PHC services, high prevalance of dracunculiasis and IMR and reported outbreaks of measles and other EPI diseases will receive priority for inclusion in the programme. In 1994 and 1995, the programme will facilitate the convergence of new programmes and projects in 46 model local government areas with a combined population of 11.5 million people, about one third of the population of the eight focus states. There will be six programmes: PHC; household food security and nutrition; water supply and sanitation; basic education; advocacy and social mobilization; and planning, monitoring and evaluation. There will also be a small area-based programme for children in especially difficult circumstances in two urban local government areas.

Primary health care

26. At the national level, the health programme will include policy promotion and management support to the health sector in general, and PHC in particular. The priorities for national policy promotion include nutrition and micronutrient disorders. The programme will also aim to build Bamako Initiative principles and strategies developed in the 46 model local government areas into the national PHC programme. It will also include EPI and ORT/CDD projects to maintain UCI and ORT in all states. At the subnational level, the programme will consist of management support for PHC in the 155 local government areas of the focus states and the development and testing of community-based PHC systems from points of first referral upwards in the model local government areas. Another project will introduce Ivermectin for the treatment and prophylaxis of river blindness in endemic areas of 12 local government areas in four of the focus states. The Bamako Initiative will be the main strategy for strengthening the operation of PHC at the community level by reinforcing management systems and community participation based on cost-sharing. The strategy includes micro-planning, social mobilization and programme monitoring and emphasizes the training of qualified staff, village health workers (VHWs) and TBAs in correct case management and appropriate preventive measures. This will serve as a vehicle for growth monitoring and initiatives in the control of key diseases such as ARI, malaria and micronutrient disorders.

27. The national objective is to reduce EPI disease incidence by 65 per cent by 1995 and polio incidence to one case per 100,000 people by immunizing at least 85 per cent of children under one year old and women of child-bearing age. In the focus states, the programme will adopt a disease control and eradication strategy. The subnational impact objective is to reduce measles deaths and the incidence of neonatal tetanus by 50 per cent by 1995. Key activities will include increasing outreach, strengthening logistics and the cold chain, intensifying mobilization and advocacy, training and retraining 5,000 health workers annually and promoting periodic acceleration activities. The project will strengthen sentinel surveillance and set up a computerized data bank for improved monitoring. A major priority of the first year will be to establish baseline benchmarks for the programme. The Government and Rotary

International will provide vaccines, while UNICEF and state or local governments will provide other supplies.

28. The national CDD project will assist in setting up 1,500 ORT units in existing health facilities. It will train one health worker per facility in the clinical management of diarrhoea and CDD in the household and the community. VHWs and TBAs will undergo training and retraining. The project will include supervisory management skills training for all 453 local government area project managers and the mobilization and training of health professionals and NGOs. The subnational impact objective is to strengthen CDD and reduce the diarrhoea incidence rate among children under five years old from 4.3 to 3.7 episodes per year.

Household food security and nutrition

29. The objective is to reduce malnutrition among pre-school children from 22 to 11 per cent for moderate malnutrition and from 14 to 7 per cent for severe malnutrition by the end of 1995. The programme will improve household and community understanding of the causes and prevention of malnutrition and will improve the availability and use of basic staple food in households throughout the year. It will give priority to children between the ages of 12 and 36 months, pregnant women and women farmers. It will consist of four projects: infant and young child feeding; food production; food processing and storage; and food and nutrition policy development. These will operate in the model local government areas and provide improved planting materials and field-level assistance and training in nutrition and in appropriate crop and livestock production techniques. They will introduce technologies for the improved processing, packaging and preservation of food. The programme will set up at least six seed multiplication sites in each local government area and support operational research as a basis for food and nutrition policy development.

Water supply and sanitation

30. The programme will assist integrated water supply and sanitation and health education programmes in 11 States that contain 80 per cent of reported cases of dracunculiasis. Within the framework of the sector goals for widespread access, the programme will contribute to the elimination of dracunculiasis in the focus states and work with other agencies to achieve national elimination by 1995. The programme will strengthen the capacity of states and other agencies to accelerate access to safe water from 22 to 38 per cent and to safe sanitation from 15 to 40 per cent by 1995. The programme will consist of five projects: water supply; sanitation; hygiene and health education; elimination of dracunculiasis; and national water and sanitation support. It will provide 6,240 boreholes and 9,980 wells; improve 2,620 traditional sources; encourage the safe disposal of excreta through latrine technology; and train village-based workers in health education.

Basic education

31. Emphasis in 1991 will be on the preparation of a basic education programme for 1992-1995 along the lines of the Jomtien Declaration on Education for All. There will be two additional projects: education for women; and early child care, development and education. The former will boost functional literacy through women's and mass non-formal education programmes and education centres for girls and women. It will support the revision of different adult and non-formal education curricula to include messages for CSD. The early child-care project will use affordable community- and family-based approaches for the stimulation of pre-school children through health, nutrition, psycho-motor and cognitive development activities. The project includes the training of early childhood educators and the setting up of community-based child-care centres.

Children in especially difficult circumstances

32. UNICEF will assist a pilot programme to improve the income-generating capacity and living conditions of families with street working children in two local government area capital cities. There will be three projects: (a) development of a database and situation analysis; (b) learning, training and earning; and (c) NGO capacity-building. A situation analysis will cover all state capitals. Two other projects will be implemented in Calabar and Kaduna. The learning, training and earning project will develop income-generating and training opportunities for working children and their mothers. NGOs will be assisted in enhancing the income-generating capacity of families, communities and training institutions. Lessons from these projects will enrich the development of a national policy on working children.

Advocacy and social mobilization

33. This programme will aim to sustain and increase political commitment to child survival, protection and development through appropriate policy- and budget-making. It will improve the knowledge, attitudes, and practices and upgrade the communication skills of mass media workers and service providers in health, nutrition, education and related fields. There will be five projects: advocacy; mass media capacity-building; empowerment of families; community participation; and mobilization of NGOs. These will take place at the national level, but will give priority to the focus States. Project activities include dissemination of information, capacity-building in the mass media, a sustained and consistent training programme, collaboration with NGOs and the production and programming of a wide range of audio-visual and printed materials. The programme includes activities to facilitate the development and communication of a national policy on AIDS.

Planning, monitoring and evaluation

34. This programme will improve both the quality of information in programmes and projects and the reliability of data on the situation of children and women in Nigeria. It will set up sustainable systems for gathering, analysing

and using information on field activities for programming and advocacy. It will build capacity to plan, manage, monitor and evaluate projects in a cost-effective manner at all levels. It will consist of four projects: development of State data banks; planning and programming; monitoring the situation of children and women; and research and evaluation. Main activities include the training of managers and supervisors in programming, micro-planning and monitoring skills, the setting up of monitoring systems and the design and implementation of operational research and evaluation. The programme will be national in scope, but give priority to the focus states for systems development and training in planning, programming, monitoring and evaluation. Many partners, including government ministries, universities, research institutes and NGOs, will be involved. The planning and programming development project includes pilot activities to link teams from two Nigerian universities with communities so that they may both improve their research capabilities and strengthen service delivery.

35. In support of the National Programme of Action for implementing the Declaration of the World Summit for Children, UNICEF will assist the Government in designing a set of indicators and establish a system for monitoring progress towards global goals. The project to monitor the situation of children and women and undertake continuous reviews of the social impact of SAP will contribute to this. The Government will be assisted to reorient investments in favour of vulnerable groups and to target low-cost, high-impact projects to the most vulnerable. Monitoring and evaluation indicators for the country programme will include the percentage of children immunized with all antigens by their first birthday; women of child-bearing age immunized with two doses of tetanus toxoid; newborn babies with weight below 2,500 grams; deliveries attended by a trained health worker; children with weight-for-age below the third percentile; population living within 200 metres of a potable source of water; population living within 50 metres of a pit latrine or toilet; and women of child-bearing age who are functionally literate.

Coordination with other agencies

36. Joint planning sessions organized by the Federal Ministry of Health with UNICEF, the World Health Organization, the United States Agency for International Development/Combating Communicable Childhood Diseases and Rotary International will continue to ensure proper coordination with other agencies in programme implementation. Mechanisms are also in place to ensure coordination with the United Nations Development Programme, the World Bank, the European Economic Community, the Canadian International Development Agency, the Japanese International Cooperation Agency and the British Council, particularly in the water supply sector. The support of the Government of the Netherlands in household food security and early child care and development will continue.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Nigeria (1989 and earlier years)

UNICEF country classification

Under-five mortality rate	170 (1989)	Very high U5MR
Infant mortality rate	102 (1989)	Very high IMR
GNP per capita	$ 290 (1988)	Low GNP
Total population	105 million (1989)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1989
Births	(thousands)	2987	3723	4371	4931
Infant deaths (under 1)	(thousands)	421	443	481	503
Under-five deaths	(thousands)	702	737	800	838
Under-five mortality rate (per 1,000 live births)		235	198	183	170
Infant mortality rate (under 1) (per 1,000 live births)		141	119	110	102

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1980/1987)	Moderate & severe	..	..
	Severe	..	..
Babies with low birth weight (%, 1979/1983)		18	20*
Children completing primary level (% of first grade, 1980/1987)		..	63*

NUTRITION INDICATORS	About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1989)	../../..	90*/ 70*/ 64*
Prevalence of wasting (%, 1980/1983-1984)	16	21a/
Prevalence of stunting (%, 1980/1985)	..	..
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)	95	90
Food production per capita index (Index 1979-1981=100, 1980/1989)	104	95
Household expenditure (% of total income, 1980-1985)	All food/cereals	52/ 18

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1987-1988)			35
Access to health services	Total	35	66
(% of population, 1980/1989)	Urban/rural	75/ 25	85 / 62
Access to safe water	Total	28	33*
(% of population, 1980/1989)	Urban/rural	68/ 18	58*/ 22*
Access to adequate sanitation	Total	..	..
(% of population, 1980/1987)	Urban/rural	../..	.. / 5
Births attended by trained personnel (%, 1980/1988)		40	38*
Maternal mortality rate (per 100,000 live births, 1979/1988)		..	800

Immunization		1981	1985	1988	1989
One-year-olds (%) immunized against:	Tuberculosis	23	19	72	..
	DPT	24	10	58	..
	Polio	24	10	57	..
	Measles	55	14	59	..
Pregnant women (%) immunized against	Tetanus	11	7	21	..

TABLE 1 (continued)

Nigeria

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	97/ ..	66/ ..
(%, 1980/1988)	Male	110/ ..	68/ ..
	Female	84/ ..	63/ ..
Secondary enrolment ratio (gross/net)	Total	19/ ..	23/ ..
(%, 1980/1988)	Male	24/ ..	28/ ..
	Female	13/ ..	18/ ..
Adult literacy rate, 15 years & older	Total	25	43
(%, 1970/1985)	Male/female	35/ 14	55/ 31
Radio/television sets (per 1,000 population, 1980/1988)		../6	164/6

DEMOGRAPHIC INDICATORS		1970	1980	1985	1989	2000**
Total population	(millions)	56.6	78.4	92.0	105.0	149.6
Population aged 0-15 years	(millions)	..	40.6	45.2	52.1	80.1
Population aged 0-4 years	(millions)	..	16.0	17.8	20.5	30.4
Urban population (% of total)		20	27	31	35	43
Life expectancy at birth	Total	44	48	50	51	56
(years)	Male	42	46	48	49	54
	Female	45	49	51	53	57
Total fertility rate		6.9	6.9	6.9	6.9	5.9
Crude birth rate (per 1,000 population)		50	49	49	48	43
Crude death rate (per 1,000 population)		21	18	16	15	12

		About 1980	Most recent
Contraceptive prevalence rate (%, 1981-1982)		..	5
Population annual growth rate	Total	2.5	3.2
(%, 1965-1980/1980-1989)	Urban	4.8	5.9

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1988)		4.2	-4.3
Inflation rate (%, 1965-1980/1980-1988)		14	12
Population in absolute poverty (%, 1977/1988)	Urban/rural	../..	../ ..
Household income share (%, 1977/1988)	Top 20%/bottom 40%	../..	../ ..
Government expenditure	Health/education	../ ..	1 / 3
(% of total expenditure, 1980/1987)	Defence	..	3
Household expenditure (% of total income, 1980-1985)	Health/education		3/ 4
Official development assistance:	$US millions	36	119
(1980/1988)	As % of GNP	0	0
Debt service (% of goods & services exports, 1980/1988)		2	24

a/ Aged 0-59 months, rural only.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1989-1990

(In thousands of United States dollars)

COUNTRY: NIGERIA
LATEST BOARD APPROVAL: 1989
GENERAL RESOURCES: $29,000,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	13196	9570	225	126	1548	148	2005	223	16974	10067	27041
Water supply and sanitation	2910	258	75		874	2	184	135	4043	395	4438
Nutrition	507	63		2		14	32	9	539	88	627
Education		2					12	7	12	9	21
Community organization and development	315	647	54	27		63	65	184	434	921	1355
Young child development		193		5		28	10	40	10	266	276
Women-centred programme								5		5	5
Advocacy	384	128	7	40	151		119	390	661	558	1219
Planning and project support	3231	43	107	17	646		392	495	4376	555	4931
Freight	454								454		454
GRAND TOTAL	20997	10904	468	217	3219	255	2819	1488	27503	12864	40367

GR = General resources.
FSF = Funded supplementary funding.

TABLE 3. PLANNED EXPENDITURE, 1991-1995

(In thousands of United States dollars)

Country: NIGERIA Period covered: 1991-1995	Funding status	1991	1992	1993	1994	1995	Total
Health	GR	4965	4998	5010	4950	4890	24813
	NSF	4899	4995	5000	5000	5085	24979
Water supply and sanitation	GR	2680	2545	2755	2870	2800	13650
	NSF	3076	2310	2306	2129	2399	12220
Household food security	GR	1556	1553	1448	1530	1540	7627
	NSF	1810	2000	2032	2175	1904	9921
Education	GR	2208	2200	2275	2120	2140	10943
	NSF	1695	2138	2093	2180	2192	10298
Children in especially difficult circumstances	GR	135	125	86	74	51	471
	NSF	190	202	160	146	95	793
Social mobilization and advocacy	GR	646	709	617	636	646	3254
	NSF	175	185	225	225	190	1000
Planning and social statistics	GR	810	870	809	820	933	4242
	NSF	155	170	184	145	135	789
TOTAL	GR	13000	13000	13000	13000	13000	65000
	NSF	12000	12000	12000	12000	12000	60000
GRAND TOTAL		25000	25000	25000	25000	25000	125000

GR = General resources.
NSF = New supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: NIGERIA	Number of posts	Amount (thousands of United States dollars)
FINANCED FROM 1992-1993 PROPOSED BUDGET:		
International Professional established posts	4	952
Local national Professional and General Service established posts	40	1265
Operating costs		1803
Total	44	4020
FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	19	4139
Supplementary funds	2	452
Local national Professional and General Service project posts		
General resources	73	2567
Supplementary funds	14	390
Total	108	7548

a/ For information source, see 1992 post authorization table, dated January 1991.